General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: B Singh, 6 Church Street, Paddock, HUDDERSFIELD, West Yorkshire, HD1 4TR

Pharmacy reference: 1039590

Type of pharmacy: Community

Date of inspection: 23/09/2019

Pharmacy context

The pharmacy is in a parade of shop in Paddock. Pharmacy team members mainly dispense NHS prescriptions. They sell a range of over-the-counter medicines. And offer a head lice detection and treatment service. Pharmacy team members provide a substance misuse service, including supervised consumption. And, they supply medicines to people in multi-compartmental compliance packs.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has procedures in place to identify and manage risks to its services. And, pharmacy team members have read the procedures relevant to their roles. Pharmacy team members know how to keep people's information secure. And, they know what to do if there is a concern about the welfare of a child or vulnerable adult. They keep the records required by law. Pharmacists record and discuss mistakes that happen. They use this information to learn and make some changes to help prevent similar mistakes happening again. But, they don't always record or discuss enough detail about why these mistakes happen. Or, frequently analyse the data for patterns. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And, the owner reviewed them every two years. The sample checked were last reviewed in April 2019. And the next review was scheduled for April 2021. Pharmacy team members had read and signed the SOPs after the last review. The pharmacy did not document roles in the procedures. But, the owner said that roles and tasks were defined verbally.

All dispensing activities were carried out by pharmacists. And, they organised their dispensing process so that one pharmacist dispensed and assembled a prescription, and another checked the prescription. This was seen frequently during the inspection. The pharmacist checking highlighted near miss errors made by other pharmacists when dispensing. They recorded their own mistakes. They discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. The most common error in the records seen were labelling errors. The owner said this was because of repeating dosage instruction from previous prescriptions dispensed. Labelling errors had consistently been the most common mistake since March 2019. The pharmacy had changed its dispensing process in April or May 2019 so the pharmacists did not automatically repeat dosage instructions from previous electronic records. And, it had changed the computer's setup so that dosage instructions could not be repeated if it had been more than a year since the medicine had last been dispensed. But, the team had not reflected about whether their changes had worked to reduce the risk of labelling errors. And, labelling errors were still being recorded as the most common. One of the pharmacists analysed the data collected about mistakes once a year. And, they recorded their analysis. One pattern identified in the last analysis, as well as common labelling errors, was errors with look-alike and sound-alike (LASA) medicines. So, pharmacy team members had separated some LASA medicines to prevent picking errors, such as bicalutamide and bumetanide. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using a template reporting form. The latest record available was from 2014. And, the record contained information about what had happened and who had been involved. But, it did not document any information about the causes of the error or the steps taken by the team to prevent a recurrence. Pharmacy team members said they had not had a dispensing error since.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. One feedback point was having somewhere to speak to pharmacy team members privately. So, the owners were in the process of improving access

to a consultation room in the pharmacy.

The pharmacy had up-to-date professional indemnity insurance in place. It had a certificate of insurance available. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity after each entry was made. But, CDs not used frequently were not frequently audited. A pharmacist said he audited all CDs every three to four months. But, he did not document his checks. So, it might be difficult to resolve any mistakes or discrepancies quickly. The pharmacy audited methadone registers every week. It kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. And, it shredded confidential waste. Pharmacy team members had been trained to protect privacy and confidentiality. The owner had delivered the training verbally. Pharmacy team members were clear about how important it was to protect confidentiality. But, there was no procedure in place detailing requirements under the General Data Protection Regulations (GDPR). A pharmacist said he had taken the procedure home to review. He gave an assurance that he would be return the procedure to the pharmacy the next day.

The pharmacists present gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to local safeguarding contacts to seek advice. And, they were clear about when to refer a concern to the police. The pharmacy had contact details available for the local safeguarding service. All pharmacists trained every two years. The pharmacists had verbally trained the medicines counter assistant. The pharmacy had a procedure in place to instruct team members about what to do in the event of a concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the appropriate skills for the services provided. The pharmacists complete the dispensing tasks and another qualified team member helps people at the pharmacy counter. The pharmacists keep their skills and knowledge up to date as part of their professional registration. And they support the other team member to complete ad-hoc training relevant to their role. They reflect on their own performance. And set objectives to improve their knowledge when they need to. They feel comfortable discussing issues and acting on ideas to support the effective delivery of services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were two pharmacists. The pharmacy employed a further pharmacist and a medicines counter assistant (MCA). The pharmacists kept their knowledge up to date by completing mandatory revalidation as part of their professional registration. The MCA completed training ad-hoc by reading various training materials. And, they had regular training discussion with the pharmacists about relevant topics. A pharmacist said they also provided the MCA with updates about new products, changes to pharmacy law and product alerts and recalls. The pharmacy had an appraisal process in place for the MCA. They received an appraisal with a pharmacist every year. And, they set objectives to help address areas for improvement. One recent example was an objective in line with the pharmacy's ambition to become a healthy living pharmacy. This was discussed at the appraisal. And, they discussed how the MCA could contribute to the goal. The MCA's objective was to create and manage a healthy living zone in the pharmacy to promote health awareness.

A pharmacist explained they would raise professional concerns with the pharmacy owner or the GPhC. They said that because it was a family business, they felt comfortable raising a concern. And confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And, pharmacy team members knew how to access the policy. Pharmacy team members communicated with an open working dialogue during the inspection.

A pharmacist had identified a personal area for improvement. He explained that a recent peer-review had highlighted the need to improve his consultation and questioning skills to help improve interactions with people asking for advice. He had since completed training on consultation technique and handling conflict. And, he said that although he had not had a chance to practice his skills yet, he felt more comfortable and confident to approach and handle difficult discussion during consultations with people. The pharmacy owners did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. The pharmacy had very little bench space for the volume of dispensing being carried out. But, most areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a first floor, which was used for storage. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door. The pharmacy owners were in the process of improving access to the room.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is generally accessible to people. And, it has systems in place to help provide its services safely and effectively. It sources and manages its medicines safely. And it generally stores its medicines appropriately. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And, they provide these people with the information they need to identify their medicines. They take steps to identify people taking high-risk medicines. And, they give these people advice to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessed via a ramp from the street. It had a sign on the door instructing people to ask if they needed help. But, it did not instruct people how to get a pharmacy team member's attention if help was required. A pharmacist said people usually knocked on the door. And, they gave some examples of people who could not get out of the car that would telephone the pharmacy. And, a team member would go to the car to help them. A pharmacist explained they would use written communication with someone with hearing impairment. And, they could produce large print labels to help people with a visual impairment.

Pharmacy team members sometimes signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. But, in some of the sample seen, some boxes had not been signed. And, there were examples where neither box had been signed. This was discussed, and the owner gave an assurance that both boxes would be signed in future to help maintain an audit trail. Pharmacy team members used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It attached labels to the pack, so people had written instructions of how to take the medicines. And it added the descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines approximately every two months. And, they documented any changes to medicines provided in packs on the patient's electronic record. A pharmacist explained that an assessment was carried out with each patient asking for their medicines to be supplied in a pack. And, this was to help determine if a pack was the most appropriate adjustment in each circumstance. They said they sent the record of the assessment record to the patient's GP. But, they did not keep a copy in the pharmacy. So, they did not have any documented evidence of the assessment process. This was discussed, and the pharmacists agreed that it would be sensible to keep a copy of any assessments in the pharmacy for future reference.

The pharmacists checked medicine expiry dates every 12 weeks. And, they checked the expiry dates of medicines as they were dispensed, in accordance with their documented dispensing procedure. They did not keep records of dated checks being carried out every 12 weeks. But, they highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. And, they did not have a process to make sure medicines were removed from the shelves if these expired before the next check. The pharmacy stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. But, some packs were found on the shelves that contained mixed batches of medicines. This was discussed. And, the pharmacists gave an assurance that stock would be checked and any mixed batches would be removed. The pharmacy obtained medicines from five licensed

wholesalers. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

The pharmacists counselled people receiving prescriptions for valproate if appropriate. And, checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was enrolled on a pregnancy prevention programme. The pharmacy had printed information material to give to people and to help them manage the risks. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training and procedures were in place to incorporate the necessary checks in to the dispensing process. And, the pharmacy had the necessary equipment available to scan medicines packs. Each compliant medicine pack was scanned during dispensing to check for falsified medicines. And, pharmacy team members said they would seek advice from their wholesalers if there was an issue.

The pharmacists delivered medicines to people. They recorded the deliveries made in a duplicate book, where they used one page per patient to help protect people's confidentiality. Pharmacy team members asked people to sign for their deliveries. And, they made a note of any advice given to people by the pharmacist when they delivered the medicines. Pharmacists left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy obtained equipment from appropriate suppliers. And, it had a set of clean, well maintained measures available for medicines preparation. The pharmacy positioned computer terminals away from public view. And, these were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a dispensary fridge, which was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment and they stored all items securely.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.